



## CYSTIC FIBROSIS MEDICATION - Patient Enrollment/Order Form

Complete form in its entirety and fax to number listed below

### 1 PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

### 2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



**Fax Completed Form to:**  
**Fax Number: 866-364-2673**   
**Phone Number: 800-327-1392**

### 3 Office of Vermont Health Access PRESCRIPTION CYSTIC FIBROSIS MEDICATION

#### Patient Diagnosis:

☐ Cystic Fibrosis

#### Product:

☐ Pulmozyme® (dornase alfa inhalation) 1 mg/ml 2.5 ml ampules

☐ Administer via nebulizer once daily.  
Dispense # 30 Refill \_\_\_\_ times

☐ Administer via nebulizer twice daily.  
Dispense # 60 Refill \_\_\_\_ times

☐ TOBI® (tobramycin solution for inhalation) 300 mg/5 ml ampules

Administer via nebulizer twice daily,  
alternating 28 days on and 28 days off

Dispense # 56 Refill \_\_\_\_ times

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Last Updated 03/2009